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ABSTRACT

Suggestions are made for administrators responsible for the establishment and supervision of programs and services for children who are homebound or hospitalized and for teachers of such children. The section for the administrator considers program objectives, program merits, responsibilities and supervision, pupil eligibility, referrals, termination of home instruction, teacher selection, parent responsibilities, and programs for the emotionally disturbed, severely retarded, and learning disabled. Recommendations for teachers include teacher role, supportive consultants, making a community directory, self-help, procedure subsequent to referral, initial home visit and lesson, the hospital setting, team conferences, time for instruction, and record-keeping. Types of programs and aids and a glossary are also included. (RJ)

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The Provision of Education for Pupils who are Homebound or Hospitalized

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The Provision of Education for Pupils who are Homebound or Hospitalized

Special Education Branch
Department of Education
Province of Ontario
Toronto, Ontario

1971

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Preface

The material within this publication offers suggestions for (i) administrators responsible for the establishment and supervision of programs and services for children and youth who are homebound or hospitalized, and (ii) teachers of such children and youth. It attempts to present a few guidelines and to indicate current trends. Extensive details may be found in reference books and resource materials pertaining to the subject.

Principles upon which suggestions are based include the following points:

It is the right of every child to have access to a learning program that will lead him to develop mentally to his optimum capacity. It is the responsibility of the educational authority to provide facilities, resources, and personnel to enable him to reach this goal. No child is expendable.

In any program the welfare of each individual child must be paramount.

All children with disabilities should be permitted to enter regular school programs on a part-time or full-time basis when their development so warrants.

If we are truly to help the child who is different, we must be preoccupied not with his handicaps or his weaknesses, but with his potential and his strengths. He must be accommodated by programs, services, and curriculum that will enable him to mature and to learn as much as his capabilities permit in an atmosphere of self-respect and dignity.

Education is for leisure time, for a more mature culture, and for a greater sense of personal responsibility. It should encourage discussion, inquiry, and experimentation. It should enhance the dignity of the individual.

An educational program for children and youth who are hospitalized or homebound is intended to be a means of inclusion in, rather than exclusion from, the total range of programs and services provided by education.

Education has therapeutic values.

Part A—Administration

I
Objectives of Programs

The primary objective is to provide educational programs of the same quality and having the same goals as the regular school programs from which, by reason of their disabilities, the children and youth are excluded. Thus an important function of the programs is to ensure continuous instruction while pupils are homebound or hospitalized and so prevent educational retardation due to absence. At the same time, teachers should aim to transfer pupils to special or regular classrooms, either on a part-time or full-time basis, as soon as they are able to attend such classes.

Enrolment in the special programs should be considered only after all possibilities for a modified program within a school have been exhausted.

II
Home and Hospital Instruction Programs

Advantages
Individualized instruction is an important advantage of these programs for it, in turn, provides several advantages. These include opportunities to remedy learning gaps, stimulate intellectual curiosity, foster multi-faceted personal development, and encourage progress at the individual child's own pace. The circumstances under which instruction is given allow the teacher to make a frank assessment of the child's level of functioning and create a favourable environment for acceptance — both by parents and pupil — of this assessment and the immediate and long-range goals determined by it.

Disadvantages
The circumstances and setting in which instruction is conducted may lead some teachers and children to regard it as a mere baby-sitting activity. Access to the teacher for only limited time periods may present further difficulties.

The disabled child's isolation is a serious disadvantage if extended for months or years. The lack of stimulation from peers, limited contact with the community, limited social and group experiences all may create a situation similar to that of the culturally disadvantaged.

To an over-protective, over-anxious, possessive parent a home instruction program may seem desirable, but the child may experience detrimental effects on his self-respect and life values.

From a practical standpoint, the task of transporting bulky instructional aids may constitute a serious disadvantage for the teacher.

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III
Responsibilities of a senior official

The first task of a senior official responsible for Special Education is to outline an overall and long-range plan for the education and the social and vocational adjustment of children and youth who are homebound or hospitalized. In formulating this plan he should check the requirements stated in the Provincial Regulations.

He should establish written policies to ensure that efficient procedures are followed concerning:

a) the placement of pupils, whether they be referrals for enrolment in a program of special education or for transfer to a regular classroom;

b) the movement of records — medical, educational, psychological — needed for planning educational programs in keeping with the child's needs and physical limitations and with medical recommendations;

c) child accounting;

d) supervision and support for teachers;

e) the acquisition and transportation of supplies and equipment for instructional purposes;

f) the reimbursement of teachers' travelling expenses;

g) the co-ordination of the efforts of the local school and of the teacher of the homebound or the hospitalized in order to effect the child's placement in a school setting with the least readjustment difficulty;

h) services to non-resident pupils (in hospital, etc.);

i) children and youth enrolled in detention homes, residences for pregnant girls, convalescent homes, or similar institutions within the community;

j) the reporting of educational progress to parents;

k) regular periodic evaluation of student needs and programming; and

l) the selection and scheduling of teachers.

For teachers of pupils who are homebound or hospitalized, a senior official responsible for Special Education should provide:

a) a home-base for maximum program co-ordination and staff morale, in which to maintain essential records and reports, to plan and prepare instructional materials, and to store instructional material and equipment;

b) a wide range of materials and equipment;

c) opportunities to participate in in-service programs related to their own activities, all facets of special education, and trends in education in general, in order to minimize feelings of isolation and stagnation;

d) supportive assistance from specialists — consultants, supervisors, master teachers — in the various subject areas (e.g. music, art, physical and health education, speech correction, science) as well as the full resources of ancillary special education and student services personnel;

e) adequate time for preparation and planning, and for conferences with parents or others involved with a child;

f) clearly defined procedures concerning the enrolment and the transfer of pupils, the acquisition of supplies, travelling expenses, and lines of responsibility and authority;

g) parking arrangements with the proper authority when a teacher is giving instruction in a hospital, a residence for pregnant girls, a detention home, a convalescent home, or a private home in a restricted parking zone;

h) easy accessibility to pertinent records concerning pupils; and

i) adequate health protection from contact with communicable diseases, fatigue, and undue frustration.

Further, it is the responsibility of the Special Education Senior Official to guard against the misuse of home instruction programs to disguise the need for additional educational programs and services. In devising his programs he should allow for the partial participation of many homebound children in modified programs within a school setting. Lastly, with the assistance of teachers of homebound pupils, he should be on his guard against needlessly confining to home instruction the child of an over-protective, over-anxious, possessive parent.

IV
Supervision

Often the immediate supervision of a home or hospital program is the responsibility of the principal of the school that the child or youth would ordinarily attend. An exception to this pattern might be programs for individuals who are chronically or terminally ill, for which the Special Education Senior Official may assume responsibility. In either case, supervision by a knowledgeable leader is required.

In addition to the task of supervising the instructional program, the duties of the supervisor will centre on assisting the teacher of the homebound or hospitalized. This will include securing the co-operation of parents and ensuring that they understand their responsibilities; helping teachers to select and procure appropriate educational materials and equipment for individual children; arranging conferences between regular teachers and the teacher of the homebound or hospitalized; and easing the latter's sense of isolation by arranging in-service programs and encouraging active participation in other professional meetings and activities.

The supervisor will also assist with the scheduling of teachers, taking into account the following factors:

a) travelling time (distance, traffic, and road conditions);

b) number of pupils enrolled;

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c) grade and achievement of each pupil;
d) medical recommendations concerning permissible activities;
e) treatment routines and family routines;
f) time for preparation of materials, reports, and records;
g) interviewing and planning for and with a new pupil;
h) conferences with parents and with other professionals;
i) appropriate instructional program;
j) direct and frequent communication with local school faculties; and
k) pick-up and delivery of heavy or awkward instructional materials.

The supervisor may also assist in the co-ordination of medical, psychiatric, and social work recommendations with an educational plan, and assume responsibility for interpreting home and hospital programs to other school administrators and to private physicians.

A sincere interest on the part of the principal in the progress and welfare of children or youths who are homebound or hospitalized contributes a great deal toward good community relations. His sympathetic concern will likely be reflected in co-operative attitudes among the regular classroom teachers on his staff.

V
Eligibility of pupils

No child or youth should be enrolled for home or hospital instruction without the written recommendation of a physician. The presence of one of the following conditions is assumed, and the illness referred to may be physical or emotional: (1) a chronic, long-term illness; (2) a convalescent phase of an acute illness; (3) a period of confinement to home or hospital following a traumatic episode or a surgical procedure that will require at least four weeks of restricted activity; or (4) a physical handicap that prevents regular school attendance.

It should be stressed that children or youths suffering from an infectious disease are not eligible during the contagious stages.

Page 9 of this guideline should be consulted for comments concerning home instruction for children who are emotionally disturbed or mentally handicapped.

VI
Referrals

It is important to establish clearly to whom referrals are to be made. Referrals are usually made through the principal by parents, public health nurses, or social workers.

One specific supervisor should be assigned the responsibility of allocating each pupil to a teacher of the homebound or hospitalized.

A principal or parent may place a referral by telephone. The following information may be recorded immediately: name, address, and telephone number of child; name of school and grade attended; illness and anticipated length of absence; date of referral.

When placement has been confirmed, a duplicate copy of this information should be given to the teacher who is assigned to the pupil.

A letter must be obtained from the physician or psychiatrist stating the nature and expected duration of the illness. He may present, as well, recommendations concerning restricted activities, and so forth. The school nurse may visit the home in order to obtain permission to contact the physician and to pave the way for the family's co-operation with the teacher and her schedule.

A letter of consent should be obtained from the parents. The physician may request authorization from the parent as well.

These procedures should be well co-ordinated in order to avoid more than a few days' lapse between the referral and the initiation of instruction.

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VII
Termination of home or hospital instruction

A child or youth may be removed from home/hospital instruction for one of three reasons:

1 The reason for placement on home/hospital instruction no longer exists. The illness or handicapping condition has been corrected or improved, and the doctor has given permission for the pupil to attend school.

2 The pupil no longer benefits from instruction, due to a deterioration of his condition. A statement from the physician should confirm the assessment.

3 A temporary suspension may be necessary when parents refuse to co-operate. As soon as minimum standards are met, home instruction should be resumed.

VIII
The selection of teachers

The uniqueness of a child or youth with a handicap or illness that confines him to home or hospital places him within the responsibility of special education. Optimum qualifications of visiting or itinerant teachers who participate in home and hospital programs therefore include, in addition to a basic teaching certificate and varied classroom teaching experience, (1) a rich general arts education to meet the demand for instruction at many levels in many areas; (2) specific education in facets of special education, including child growth and development, child-family relationships, the psychology of exceptionality, recognition of individual differences and needs, knowledge of severe emotional problems, experience with methods and materials for teaching multiple disabilities; and (3) knowledge and skill in the techniques of counselling and interviewing.

In order to make the best use of their particular skills and training, teachers are generally assigned to either elementary or secondary school pupils. At the secondary school level, teachers may be assigned to one or more of the following areas: mathematics and science; English and the social sciences; foreign languages; vocational subjects; and occupational pupils.

Desirable characteristics of the ideal teacher for homebound and hospitalized programs include:

1 the ability to adapt to unusual teaching situations and varied home conditions;

2 good physical and mental health, including such aspects of maturity as self-understanding, an awareness and appreciation of personal pressures, biases and prejudices that may affect situations;

3 sensitivity to and empathy for the current needs of others;

4 flexibility — the ability to shift plans, schedules, or approach, quickly and comfortably;

5 skill in public relations and the ability to get along well with others;

6 a warm, friendly personality and an appreciation of the viewpoint of others;

7 willing and optimistic acceptance of the challenge of aiding incapacitated individuals by means of educational enrichment, remediation, and adjustment, and the ability to feel at ease with severe, disfiguring physical handicaps;

8 the ability to work and to plan independently while keeping the teaching role in perspective as one part of a continuous program for the well-being of each child;

9 skill in educational diagnosis and in synthesizing the varied knowledge and concepts of many fields;

10 the ability to provide a constructive, mentally wholesome environment in spite of progressive disabilities, varying standards of order and cleanliness, and of conflicting values;

11 a keen sense of humour, cheerfulness, tact;

12 a creative imagination, an inquiring attitude, versatility.

Although teachers may be employed for home and hospital programs on either a full- or part-time basis, instruction should be provided within regular school hours. As a part of the total range of programs and services, home and hospital instruction should not be viewed as an after-hours salary supplement, or as a wearisome duty at the end of a busy daily schedule.

IX
The responsibilities of parents

Theoretically, one hour of individual instruction is equivalent to one day of regular classroom instruction. Obviously it is impractical to devote long periods to study or preparation while the instructor is present. Each visit should be spent in the presentation of new material, the explanation of new processes, and discussion of new assignments. It then becomes the student's responsibility, under the supervision of the parents or guardians, to prepare work which has been assigned. Instruction time once lost is difficult to regain, for time is at a premium in this program.

During the initial visit, the teacher usually explains the program and the schedule. Many find it helpful to prepare a form letter for parents which outlines their responsibilities. Items to be included in such a letter include the following suggestions:

Have your child ready for instruction when the teacher arrives. Keep the child's equipment (crayons, scissors, pencils, papers) together so that they are readily available for use when the teacher begins instruction.

The room in which instruction is to be given should be quiet and should have sufficient light, properly placed. All members of the family should stay out of the classroom during the instruction period, and care should be taken to avoid interruption and disturbance (loud radio or television programs, etc.).

Try to provide a comfortable working area for the child — a solid writing surface such as a card table, bedside table, or desk, and a comfortable chair. A suitable chair should be provided for the teacher.

Set aside a certain time each day in which the child is to do the work assigned. Check to see that he has completed the assignment and show an interest in his work, but refrain from helping him too much.

School books and other materials left for the child's use should be returned in good condition to the special teacher when the child returns to school. (This is an expensive program. The child should attend a school as soon as the doctor will give permission.)

If for any reason the child cannot take his instruction period on a particular day, kindly contact the teacher or supervisor by telephone before 8:00 a.m. or 1:00 p.m., so that the teacher may use the time to assist another child.

Please adhere to the schedule for instruction as closely as possible.

X
Programs for pupils who are emotionally disturbed or mentally ill

Pupils whose behaviour is so peculiar as to interfere significantly with the progress of others, those who make disturbing assaults on their classmates, or those who are abnormally afraid to leave home may be regarded as candidates for home instruction. It is more than likely that some of these children are seriously ill and in need of psychiatric treatment. Ideally, home instruction in such cases should be only a temporary expedient, to be resorted to until the children are transferred to a residential treatment centre.

Some children whose behaviour is such that their education cannot be conducted in the company of others may receive individual instruction in a place other than their homes. If these pupils are required to dress, walk from their homes to an office in a school or administration building at a fixed time, and work there individually with a teacher, the challenge presented is much greater than if the teacher were to visit the several homes.

When a child is unusually and persistently reluctant to leave his home, as may occur when a diagnosis of school phobia is presented, some of the following progressive steps by the home instruction teacher may prove helpful:

1 Offer instruction in the home without reference to the school building or the class activities.

2 Make casual references to the school and to the program pursued by the others of the same age group.

3 Visit the school with the pupil to borrow a book from the library or on some other pretext.

4 Take the pupil to the school to do a special test in an office apart from other children.

5 Teach the pupil in a room in the school.

6 Encourage and assist the pupil in his efforts to overcome his reluctance to attend

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one or more classes with other pupils. From time to time, remind him that he will be asked to participate in discussions only when he raises his hand and that he has permission to leave the room if he is unable to withstand the strain.

7 Offer the pupil encouragement to attend more classes and to gradually participate on an equal basis with other pupils.

8 Discontinue regular visits but buttress the pupil's morale with regular telephone calls.

9 Discharge the pupil from home instruction and transfer him to the jurisdiction of his own school.

XI
Programs for pupils who are severely mentally handicapped

The home instruction program for the trainable retarded child should be practical. Materials and instruction should be restricted to those areas that have proven of value with such children, namely, oral language development, sensory motor activities, visual and tactual training activities, basic number concepts, fine motor skills, arts and crafts, and self-help skills. Materials selected or prepared by the home instruction teacher may help parents in the follow-up program.

During the home instruction teacher's visits, activities and materials should be discussed with the parents. Daily work and play periods, some of which may involve the participation of the parents, should be planned so as not to disturb household routines or tire the child.

A daily schedule of routine activities forms the base of the program. Routine activities play a very important part in the trainable retarded child's life, his regular performance of self-help activities at home will help maintain skills acquired at school.

Outlines of carefully planned procedures will assist parents in establishing daily routines in self-help skills, sensory motor development, oral language and number games, and craft activities. The procedures for working periods should be planned in a step-by-step progression and the learning materials organized in such a way that the child may work on his own or with minimal assistance from his parents.

In order to balance the daily activities between active and passive learning, play time should be unorganized time when the child is free to play.

The main purpose of the home instruction program for the trainable retarded should be to serve as a continuation of the school program during absence from school and as preparation for the adjustments the child will have to face on his return to school.

A Sample Daily Program

8:00 a.m.	Get up, wash, clean teeth, dress.	
8:30– 9:00 a.m.	Help to get the breakfast ready. Breakfast.	Family activities
9:10– 9:30 a.m.	Wash up and put away dishes.	
9:30–10:00 a.m.	Make bed and tidy own room. Help mother with housework.	Training period in self-help skills. (follow procedures on charts)
10:00–11:00 a.m.	Work period (assignment planned for the day by the visiting teacher in speech and language development, number activities, or sensory-motor training).	
11:00–11:30 a.m.	Free play period — toys and games suitably arranged for the child to play on his own.	
11:30–12:00 p.m.	Washroom (wash hands). Help to get lunch ready, set the table.	
12:00–12:30 p.m.	Lunch.	
12:30– 1:00 p.m.	Wash up and put away dishes for mother.	Training period in self-help skills. (follow procedures on charts)
1:00– 1:30 p.m.	Rest (for mother and child).	
1:30– 2:00 p.m.	Work period (planned by the visiting teacher).	
2:00– 4:00 p.m.	Different activities each day — e.g., shopping; walk with mother; playing or working in the garden (weeding, sweep the paths, etc.); craft activities (paint, sew, draw, colour by number, etc.), picture books.	
4:00– 4:30 p.m.	Tea time.	
4:30– 5:30 p.m.	Watching television with brothers and sisters.	
5:30– 6:00 p.m.	Help to get the supper ready.	Family activities
6:00– 6:30 p.m.	Supper.	
6:30– 7:00 p.m.	Washing up.	
7:00– 8:00 p.m.	Listening to records (songs, stories, etc.); puzzles; games; cards.	Recreational and training activities
8:00– 8:30 p.m.	Get ready for bed (bath).	
8:30– 9:00 p.m.	Look at a book in bed.	Family activities
9:00 p.m.	Lights out.	

XII
Programs for pupils with learning disabilities

Children who have specific learning disabilities may require home instruction due to (a) extreme distractibility and hyperactivity in a group situation, or (b) immaturity of a degree that precludes school entrance at the normal age.

If at all possible, extremely distractible or hyperactive pupils should attend school for a period of time so that they may gain the confidence they will need to eventually adjust to and feel comfortable in a classroom situation.

The home instruction program should concentrate on academic proficiency, especially in reading and arithmetic. Ideas such as those presented in *The Slow Learner* by N.C. Kephart will be more effective than a duplication of the approach taken at school. Children with learning disabilities usually have an intense desire to succeed, and the whole purpose of the home instruction program should be to prepare them to return with proficiency to the classroom situation.

School age children who are too immature to benefit from kindergarten instruction may be taught on a home instruction program. The program involves assisting the parent rather than directly teaching the child. Ideas such as those presented in *A Parents' Guide to Learning Problems* by M. Golick will be useful in helping the parents understand their child.

The program conducted by the home instruction teacher should concentrate on communication skills in both auditory and visual perception areas.

The program to be given by the parents should involve gross and fine motor development techniques. A useful outline to follow is given in *Success Through Play* by D. H. Radler and N.C. Kephart. Care should be taken to establish a definite, limited program for the parents to follow, so that the child does not become overburdened to the exclusion of normal play. In so doing, the teacher will probably become involved with discussions of household routines, such as schedules of meals and bedtimes, which will provide the child stability in his environment.

Regular visits could be made to the school that the child will be attending, and whenever the child seems settled enough he may participate in some of the programs. The essential goal is to prepare the child for full-time school attendance.

Part B—The Teacher

XIII
Teaching in home and hospital programs

Basically the role of a teacher in a home or hospital is the same as that of classroom teachers. There are a few notable differences.

Classroom teacher	Home visiting teacher
1 School setting.	**1** Wide variety of settings.
2 Selects, constructs, organizes, and adapts appropriate educational methods and materials in order to provide skills, attitudes, appreciation, and opportunities for development.	
3 Group and individual instruction.	**3** Tutorial instruction.
4 Daily association with fellow educators.	**4** Infrequent association with fellow educators; hence a sense of isolation at times.
5 Participates in professional group activities and in-service education.	**5** Participates in the usual professional activities, plus special education activities and in-service education.
6 Plans and prepares daily programs so as to use time meaningfully and purposefully.	
7 Infrequent direct contact with homes of pupils.	**7** Regular confidential contact with home of each pupil.
8 Calls upon specialists (master teachers, principals, supervisors, consultants, counsellors, psychologists) for supportive assistance.	**8** Calls upon medical as well as educational personnel for supportive assistance.
9 Works in a stimulating, competitive teaching situation in which it is necessary to be attuned to new ideas and alert to possibilities for professional growth.	**9** Works in a non-competitive teaching situation where professional stimulation is easily avoided, giving rise to the danger of self-created stagnation.
10 Experiences periods of frustration in connection with working conditions, slow progress of some pupils, etc.	**10** Occasional sense of futility due to brevity of instructional periods, death of promising pupil, or transfer of promising pupil to an essentially custodial setting.
11 Requires skill in working co-operatively with school personnel at various levels and in different capacities.	**11** Requires skills in working effectively with all types of parents in all kinds of settings, and with allied professionals, as well as with school personnel.
12 Communicates ways of acquiring knowledge, of applying it, of testing it, and of enjoying it.	

The duty of the home and hospital teacher is to teach, not to advise or to prescribe in matters beyond the educational field. She will need to acquire, however, the ability to interpret multi-disciplinary reports

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and to understand the medical terms involved. She may also be faced with household or hospital routines that require changes or modification in the educational schedules, and co-operation.

The ability to empathize but not oversympathize is an important asset that will have to be developed early in the home teacher's career. Contacts with weary, anxious mothers in need of reassurance, advice, and support will have to be handled with controlled sympathy. A little time may be set aside for counselling sessions, but this must not become a major portion of the time assigned to instruction.

Contact with disease, death, suffering and disappointment will show up the need for a philosophy of life that provides a constructive framework for such phenomena. The teacher will need support to enable her to accept each child's projected adult life or terminal disease.

From a practical standpoint, a knowledge of streets and of safe driving in all kinds of weather is essential.

XIV
Do's for teachers

Apply your knowledge of child growth and development in evaluating a child's assets and areas of weakness and in planning a program that is to his age level. Apply all your diagnostic, prescriptive, and prognostic skills to determine appropriate curriculum, techniques, and equipment for the individual child, and to recommend a new placement when he is ready.

Use appropriate audio-visuals and teaching-learning aids. Familiarize yourself with, and have a working knowledge of, resources available in your community. Return borrowed books, supplies, and equipment promptly when a program is terminated. Recognize your own limitations and seek consultative assistance. Participate in educational meetings, conference, and workshops to gather new ideas for program planning, to gain moral support, to receive professional stimulation, and to maintain your perspective of education in general.

Keep an accurate record of the time spent in teaching each child and of his rate of progress. Note recommendations for future consideration in the educational progress of the child. Submit monthly and annual reports and reports at the termination of instruction concerning attendance and achievement.

Be a friend in each home, but a teacher to each pupil.

XV
Supportive consultants

- Subject area specialists. — These include consultants in physical and health education, arts and crafts, music, language, science, speech correction, mathematics, social sciences, primary methods, language arts, audio-visual techniques, and special education.
- Guidance or Student Services personnel
- Psychologist Services personnel
- School principals and supervisors
- Allied professionals
- Community agencies
- Regional Program Consultants and the Special Education Branch of the Ontario Department of Education.

Allied personnel

- Physicians
- Specialists (cardiologist, internist, urologist, neurologist, dermatologist, psychiatrist, etc.)
- Nurses (public health, school, hospital, Ontario Society for Crippled Children, C.N.I.B.)
- Social workers
- Occupational therapist, from whom the teacher may borrow or learn about appliances to assist pupils; prevocational testing and evaluation; and activities to increase the self-help skills needed for daily living.
- Physical therapist, from whom the teacher may learn about correct positioning for instruction, study, etc.; correct lifting procedures to prevent injury to teacher and parent (if such lifting should be necessary); prognosis for functional ambulation, improvement of walking posture, etc.; exercises and stimulating physical activity that a child may safely perform for relief during academic instruction periods.
- Recreational therapist, from who a teacher may learn about or borrow materials related to, activities (games, art, music, crafts) that a child can perform to fill in the long hours and to contribute to academic progress.
- Speech therapist, from whom a teacher may learn about procedures for the improvement of verbal communication; procedures for establishing communication in the absence of speech; and procedures for determining the level of speech or communication that may be expected.

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XVI
Build-it-yourself directory of community agencies

- Rehabilitation and vocational counsellor, from whom a teacher may learn about establishing realistic vocational goals; experiences that provide the skills needed later in vocational education or rehabilitation services; and various kinds of homebound occupations available to the chronically ill.
- Psychologist, from whom a teacher may learn about the relationship of a disability to self-concept; assessed potential and strengths; learning problems and weaknesses; and the effects of a specific traumatic experience or performance.

Accumulate a file of regional agencies and associations from whom the families of pupils who are homebound may seek guidance or assistance. If the local telephone directory does not list the nearest branch, seek information from the Ontario offices in Toronto, as listed below.

Allergy Information Organization,
5 Moford Crescent.

Big Sister Counselling Service,
34 Huntley Avenue.

Boy Scouts of Canada, 9 Jackes Avenue.

Canadian Arthritis and Rheumatism Society,
60 Overlea Blvd., Don Mills, Ontario.

Canadian Association for Children with Learning Disabilities,
88 Eglinton Avenue East, Suite 322.

Canadian Cystic Fibrosis Foundation,
51 Eglinton Avenue East.

Canadian Diabetic Association,
1491 Yonge Street.

Canadian Girl Guides Council,
50 Merton Street.

Canadian Hearing Society,
60 Bedford Road.

Canadian Heart Foundation,
1130 Bay Street.

Canadian Hemophilia Society,
165 Bloor Street East.

Canadian Mental Health Association,
52 St. Clair Avenue East.

Canadian National Institute for the Blind,
1929 Bayview Avenue.

Canadian Paraplegic Association,
153 Lyndhurst Avenue.

Multiple Sclerosis Society of Canada,
76 Avenue Road.

Muscular Dystrophy Association of Canada,
160 Bay Street.

Ontario Association of Children's Aid Societies, 32 Isabella.

Ontario Epilepsy Association,
835 Queen Street East.

Ontario Federation for the Cerebral Palsied,
350 Rumsey Road.

Ontario Association for the Mentally Retarded, 77 York Street.

Ontario Society for Crippled Children,
350 Rumsey Road.

Rehabilitation Foundation for the Disabled,
12 Overlea Blvd.

Information and/or counselling services may also be available from the following organizations:

Canada Manpower Centres

Canadian Red Cross

Ontario Department of Education,
Special Education Branch, Toronto.

Ontario Department of Health,
Hepburn Block, Queen's Park.
(a) Medical Rehabilitation Branch
(b) Mental Health Branch

Ontario Department of Social and Family Services — Rehabilitation Services,
204 Richmond Street, Toronto.

Regional Clinics

Y.M.C.A. and Y.W.C.A.

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XVII
Self-help for teachers

Membership in the Division of Educators of Homebound, Hospitalized and Classes for the Physically Handicapped within your nearest chapter of the Council for Exceptional Children brings you the following publications: the Newsletter of D.E.H.H.P.H.; Exceptional Children; and Special Education in Canada.

In addition to keeping you up to date on the literature concerning the instruction of exceptional children, membership in the C.E.C. and in the Special Education Section of the Ontario Education Association (O.E.A.) enables you to enjoy contacts with fellow special education enthusiasts and participate in annual conferences and group action on behalf of exceptional children.

Programming questions may also be discussed with your Program Consultant, Special Education, in your regional office of the Ontario Department of Education.

XVIII
Teacher's procedure subsequent to receipt of a referral

When a referral is received, immediately contact the principal of the school where the child is registered or the person in charge of the placement of the child to acknowledge the referral and arrange a meeting for the purpose of obtaining (a) the necessary academic information, (b) any relevant details that may assist you, and (c) the textbooks you will require.

As soon as the referral has been confirmed, telephone the parents or guardians to assure them that a program will begin shortly. If possible, discuss the times available for instruction and make an appointment for the initial visit.

Attend the prearranged meeting at the school and obtain from the classroom teacher and the principal information concerning recent units of work in which the pupil has participated, books being used, achievement levels, academic strengths and weaknesses, date of last attendance, and any helpful details (talents, interests, etc.) available.

XIX
The initial home visit

Attempt to understand the parents' problems and the nature of the child's disability. Be a good listener. Appraise the parents' attitude toward the child's condition and its consequences.

Explain the responsibility of the parent in the home instruction program. Acquaint the parents with your schedule and establish the time for the first lesson.

Make no promises concerning the child's promotion, academic subjects, and so forth, until you have had the opportunity to assess his capabilities and feasibility of arrangements.

Discuss the possibility of delays due to congested traffic, inclement weather, and so on. Discuss also the possible interference of unforeseeable family crises.

XX
The initial lesson

Game-type and get-acquainted techniques provide a means of observing perceptual, motor, sensory, learning, and conceptual skills without resort to school-associated tasks which may represent past failures.

Use a workbook specifically for recording assignments and rate of progress. Try to gauge the amount that may reasonably be accomplished without overtaxing the pupil's strength. State each assignment clearly.

It is generally unwise to work in the notebooks that were previously used in school. Issue new workbooks for the home/hospital program.

XXI
The hospital setting

Every effort should be made to arrange adjustments without friction in order to avoid weakening the child's sense of security and confidence. Mutual respect among educational and hospital personnel for each other's points of view and varying objectives will result in a spirit of co-operation.

The time factor is somewhat more complicated as a result of the involvement of other professional workers, established hospital routines, therapy schedules, and so forth. An inflexible, aggressive teacher will likely be considered a hostile hindrance. Close communication between the educational supervisor and hospital department heads can facilitate the smooth operation of procedures and avoid resentment concerning the teacher's role.

Beds are generally movable. A cart may be made available for transporting educational equipment and materials. The teacher can adjust her schedule to co-operate with hospital procedures.

The teacher may share some areas of instruction with hospital professionals. For example, the occupational therapist may give instruction in art, crafts or typing.

Multidisciplinary conferences should be arranged if there are contradictory points of view concerning the educational program.

XXII
Participation in team conferences

Prepare written reports concerning the child in his educational setting. You should be prepared to document your statements and to answer questions concerning the child's education, his behaviour, and his relationships, within the limits of an educational responsibility.

Ask questions concerning the child's observed behaviour and the implications of educational plans. Be prepared to present educational alternatives.

Make sure that the opinions you express are based on educational evidence, and assist in establishing channels for action. Consider the varying viewpoints and routines involved.

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XXIII
Time for instruction

Instructional periods for each child will vary in accordance with: (a) school financial resources; (b) enrolment; (c) the physical, intellectual, and emotional status of the child; (d) staff available; (e) travelling time involved; and (f) provincial regulations.

A full-time teacher in the home and hospital program may be willing occasionally to teach in the evening or on Saturday instead of a regular school morning in order to co-operate with a hospital routine or to meet with a parent, if such arrangements do not interfere with the pupil's progress and best interests and if the teacher is granted comparable free time. Once a schedule has been agreed upon, however, it should be virtually immutable.

Instruction should rarely be given by a regularly employed classroom teacher as an after-school assignment. Aside from other serious disadvantages discussed elsewhere in this guideline, such an arrangement would be subjected to interruption by unanticipated staff meetings and pressing family responsibilities.

The home-visiting teacher must be prepared for irregular lunch hours.

Depending on the distances to be travelled, the ages and disabilities of the pupils taught, a full case load for a home and hospital visiting teacher may be six to ten pupils at any one time.

XXIV
Teacher's records

1 Regular reports required by administration.

2 Records of (a) routines followed in each home or hospital setting, (b) schedules, and (c) general for use in case of teacher's illness or absence due to emergency.

3 Anecdotal records of the program for each child, his progress, and current recommendations.

4 Detailed summaries of case history data and recommendations from allied professionals or others involved with the child.

5 Educational assessments.

6 Regular reports to parents concerning educational progress.

Part C—Programming

XXV
Types of programs

The itinerant home and hospital programs are planned individually to meet the immediate and long-term needs of each pupil. Nevertheless, they may be divided into three general categories: short-term programs; long-term programs; and programs for pupils with a terminal illness.

Short-term programs

Pupils

These programs are designed for children and youths who will need the service for a very short time. Examples include children with relatively uncomplicated fractures, a temporary illness, burns or nephritis, and pupils convalescing from minor surgery or in the last few months of a pregnancy.

Objectives

1 to maintain the pupil as nearly as possible on a level with his regular class so that on his return he will have few readjustment problems;

2 to take advantage of the opportunities offered by individual instruction to achieve some remediation of basic skills and work habits, to initiate new patterns of study, or to arouse and satisfy intellectual curiosity.

Procedures

1 No special teaching procedures or devices are needed for most short-term pupils.

2 The home or hospital teacher should arrange a weekly conference with the regular classroom teacher to maintain contact between the child and his class, to pick up and return mimeographed copies of work prepared by the regular teacher for the class, to borrow books and learning aids used by the classroom teacher, and to exchange ideas.

3 Contacts between the child and his class may be encouraged by means of:

a) the installation of home-to-school telephone or teaching-by-telephone equipment to supplement the instruction given by the special teacher;

b) the exchange of letters, pictures, newsletters, compositions, and so forth, between the homebound or hospitalized pupil and his classmates;

c) visits to the home by classmates, by the classroom teacher, and by the principal, on a regular basis;

d) transferring to the home (on loan) the pupil's school desk and chair;

e) brief visits by the handicapped child and his special teacher to the school before his actual return; and

f) long-range competition centred around the mimeographed copies of classroom materials.

Easing the return to school

The home instruction teacher should arrange for part-time attendance as soon as possible, before the pupil is able to cope with full-time attendance. She should accompany the pupil, for reassurance and moral support, when he returns to school and encourage him to build self-confidence and independence.

Long-term programs

Pupils

These programs are designed for children and youths who are chronically ill and may never return to a regular classroom, and may never have been in school.

Objectives

1 to help the pupil prepare for adult life in accordance with the best prognosis available;

2 to provide realistic vocational and occupational guidance and training;

3 to encourage social experiences wherever possible;

4 to develop satisfying interests and talents;

5 to assist in the adjustment of the pupil and his parents to the disability;

6 to encourage the pupil to participate in the life and activities of his family;

7 to stimulate independent thought and activity;

8 to encourage reasonable standards and evidences of accomplishment without frustration;

9 to build a sense of self-worth and of security. (His contributions and return to the mainstream of society are considerably less important.)

Goals

The goals of the program may range all the way from full preparation for post-secondary education to academic training sufficient for restricted vocational competence or to the acquisition of basic skills for satisfying and useful leisure-time activities.

Procedures

A thorough, multidisciplinary assessment is basic to the setting of realistic long-range goals and to immediate program planning. Physical capabilities, intellectual potential, medical prognosis, and the possibility of ultimate special placement must be considered in formulating educational plans.

The teacher should plan the child's educational program in the light of his current condition, his individual interests, and of his probable future possibilities in order to help him achieve satisfaction in the present and his greatest development in the future despite his handicap.

For the academically capable who may be able to achieve higher levels of education, the teacher should seek the co-operation and consent of a local school from which the student may officially graduate. Arrangements should be made for any desirable adjustments in the requirements for graduation.

The teacher must consider carefully the wisdom of maintaining close contacts with regular classrooms; it may not always be kind to attempt to do so. In order to widen the pupil's interest in the outside world, the co-operation of community agencies and special interest groups may be enlisted.

For youths at the secondary school level, instruction by subject specialists and extra emphasis on vocational habilitation may become necessary. The pupil's independent study skills and the use of assignments, materials, and academic experiences parallel to his age group's regular school programs are important.

Appropriate equipment must be available on loan — typewriter, business machines, shop tools, sewing machine, reference books and publications, laboratory kits, and so forth. Two or three subjects at any one time are recommended. Four subjects may be offered on a short-term basis.

Each student must be guided toward a realistic view of the total picture; future problems need to be anticipated, identified, and solved.

Curriculum Suggestions

Emphasize skills in reading, listening, and communicating as much as is appropriate to the individual student. Select academic skills and concepts appropriate to the pupil's age and capabilities. A central theme or problem may be used to correlate various subject areas into a meaningful experience.

Music may offer effective avenues for reaching the adolescent pupil. The teacher should aim to know and appreciate a variety of types of music. She may wish to learn to play a recorder or to sing.

Recreational activities should provide opportunities:

a) to develop skills, interests, and hobbies which make life more meaningful and constructive;

b) for socialization and for physical and emotional development;

c) for exposure to movement, color, and touch games for sensory skills — visual and auditory discrimination, recognition of shapes, auditory and visual memory, spatial relationships.

The teacher may wish to teach the adolescent non-reader to read through lessons in typing. In Lessons One and Two:

a) teach the parts of the machine, their interrelationship, and the need for meticulous care;

b) trace a pair of hands and label for the touch-typing pattern.

Lesson Three may consist of the following procedures:

a) random but rhythmic stroking

b) sounding letters as they are typed

c) experimentation with eye-hand control

d) use of space bar

e) usual lesson 1 words — type and read.

In planning a remedial health program, the teacher must take into account the need for regular rest periods, dietary adjustments, capacity to participate, and so forth. Such a program should emphasize routine health habits and assist the pupil to accept his physical limitations, learn to tolerate frustrations, and understand various reactions toward handicapped individuals. It should also teach him social skills that help others to feel comfortable.

In teaching English as a second language, the teacher may involve concurrent teaching of listening, speaking, and reading and writing (repeating), but should emphasize oral proficiency. The program should make use of phonic games, conversation, role-playing, reports, pictures, charts, flash cards,flannel graph, and other methods and materials employed by regular teachers of English as a second language.

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Teaching Suggestions

The teacher should make use of all the usual audio-visual aids and instructional aids found in regular school programs.

In planning field trips, the following factors must be considered and arrangements made accordingly:

a) medical directives

b) distances

c) vehicles and modes of transportation

d) location of stairs and width of doors

e) the accessibility of food and toilet facilities

f) noise factors

g) possible emergencies and the effects of movement and excitement.

Guest visits may be arranged with the consent and assistance of the pupil. The teacher should make sure that such visits are not made out of a sense of sympathy or duty. Guests may be firemen, a local craftsman, an author, another homebound or hospitalized pupil, a horticulturist, a work party of peers involved in a mutual project, a beautician.

In preparing for visits from other children, the teacher should work closely with the parents and plan carefully to avoid over-excitement, fatigue, or tension. Activities may include monopoly, checkers, chess, hobby crafts, and so forth.

If the pupil is ambulatory, a short field trip or a visit to a school for a special occasion such as an assembly or a field day may be considered.

For homebound pupils who can be transported, a public speaking and/or debating party held in the home of one of the pupils and attended by their parents and specially invited guests may prove a stimulating project.

Programs for pupils with a terminal illness

Objectives

1 to enhance the quality of the pupil's limited life by encouraging social experiences wherever possible and developing satisfying interests and talents;

2 to encourage active participation in the life and activities of his family and build a sense of security;

3 to stimulate independent thought and activity and thereby build a sense of self-worth and self-reliance;

4 to provide opportunities for the child and his parents to deal with their anxious feelings openly and constructively;

5 to provide support for members of the family and assist them to cope with the inevitability of death.

Procedures

Modifications of curriculum will vary with the interests and ability of the pupil. There is no value in being overly concerned about paralleling peer-group activities. Any academic, recreation, or fun-type activities that are of interest to the pupil and are realistic in relation to his capabilities should be explored.

It is important to follow medical restrictions or limitations carefully as the child's condition changes. The teacher should communicate regularly with the physician in charge, the nurse, and the social worker assigned to the case.

The teacher is in a position to help both child and parents to face the crisis of death and to carry on effectively. Children often cope with their feelings about death and dying more realistically than adults expect. If they cannot cope with the emotions roused by a particular crisis, they readily transfer their feelings onto some less threatening situation. The teacher will find it helpful to enlist the assistance of trained counsellors (psychologist, theologian, etc.).

General suggestion

For some pupils, instruction at home or in hospital or a maternity residence may be a most welcome diversion during the summer vacation months. Following an acute illness or during a prolonged confinement, a child or youth will usually welcome at least an hour of daily instruction, which may take the form of active or passive participation, or both. Assigned study periods, project work or homework (art, research, handicrafts) help to occupy many hours pleasurably. A senior student may serve as a tutor.

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XXVI
Instructional aids

Learning devices and teaching aids are not sufficient in themselves. The teacher must select and plan carefully to use each aid within a prescribed structure designed to promote directed exploration and growth. Each purchase should be made in the light of:

a) the conditions necessary for its use;

b) its value for the best educational advantage of the greatest number of pupils;

c) the physical ability of pupils who may use it; and

d) maneuverability and portability.

1 Home-to-School Telephone Service

It is important to remember that this service is a *supplement* to instruction by the home teacher and not a substitute for it, although it may decrease the number of home visits required. It is most suitable for pupils over ten years of age and of average, or above average, intelligence, who are capable of working independently without constant supervision. In all cases, the physician's approval is important.

The service involves speaker microphones in both classroom and home and a private telephone line, so that the pupil is able to participate in classroom discussions. Evaluation of progress becomes the dual responsibility of the classroom and the home-visiting teachers.

2 Tele-class

This service is most effective with students twelve years of age or over, of average intelligence, and independent work habits. Students receive daily instruction. A teacher operates a conference-type telephone that accommodates as many as twenty students at one time. The students have a single purpose instrument to be used only for lessons. The teacher may connect several students for a group discussion while she continues a lesson with other students in the class.

Advantages for the teacher include elimination of transportation problems and increased time for teaching and preparing lessons. One day per week may be set aside for home visiting.

Educational television and prerecorded tapes may become important adjuncts. Computer-to-home via telephone lessons may also become practicable in the near future.

3 Tele-Hints (for students and parents)

a) Avoid making appointments which conflict with your class schedule. When conflicts cannot be avoided, notify your teacher in advance.

b) Have materials ready, and be prepared to answer the call for each class promptly. When you have answered, stay on the line while the rest of the class is being called. If your are accidentally disconnected, hang up so that the teacher may call you back.

c) Make sure you understand assignments; take part in class discussions; ask questions.

d) Tele-class requires your whole attention. Background noises in your home will disturb the entire class.

4 Literature from community agencies and societies.

5 Lending facilities of libraries, museums, and art galleries.

6 Television and radio programs (introduced and reinforced during instruction).

7 Electronics equipment of high quality and portable size; record.

8 Tape recorders, ear phones, master tapes, student practice tapes, cartridge-type tapes, amplified head sets, boom microphones, etc.

9 Films, filmstrips, slides, reverse-screen type projector, ceiling projector, microfilm, etc.

10 Lightweight collapsible overhead projector, transparencies.

11 Flannel board, display board, abacus, charts, small globe, foldable maps, etc.

12 Supply of pencils, small pencil sharpener, paper, notebooks, take-apart expendable workbooks, textbooks used in regular and in special classes.

13 Flash cards, assorted games and puzzles, basic science kit, manipulative materials, models, puppets, pictures, counting materials, etc.

14 Auto-instructional machines e.g., Language Master (Bell and Howell); Learning Systems for Special Education (T.R. Services, Toronto); Studyscope (Grant Erwin); Craig Reader (Bank Electronics, Scarborough); E.D.L. equipment.

15 a) *Welcome Amigo* — Manipulative materials for young children learning English as a second language. Source: Noble and Noble of New York City.

b) *Language Lotto* — Source: Appleton-Century Crofts of New York City.

c) *Mott Basic Language Skills* for adolescents learning English as a second language. Source: Allied Education Council of Chicago, Illinois.

16 Pictures to accompany materials being used.

17 *Keyboard Town Story Typewriting System* by A. M. and J. J. Gallagher, published by Follett Publishing Company. This book is designed for slow learners.

18 Language development kits.

19 Perception development kits and programs.

XXVII
The pupil

Although most of this publication is concerned with organizational problems of the administrator and the teacher, the most important individual in the programs is the pupil. All suggestions made in this guideline are intended to reflect the needs and best interests of the individual child or youth. Consequently, procedures and programs must remain subject to change or modification whenever required for a specific pupil and his physical well being, his social adjustment, his emotional balance, and his academic development.

Educational plans must reflect continuing sensitivity to the realities of the individual child's psychological needs for security, variety, sense of adequacy and of belonging, affection, and orientation or contact with reality. Whether his confinement is to be brief or lengthy, a sick child sees himself as different from his former active and healthy self. In his new or current condition, he may find himself confronted by physical handicaps that seriously restrict his activities. He may be confined to a prone position, have one of his senses temporarily or permanently impaired, suffer a loss of manual dexterity, and find himself unable to study or to concentrate for even short periods. These limitations usually lead to adverse psychological consequences. The child is likely to feel disoriented, confused, and frustrated; become easily discouraged and defeated; and see himself as less worthy and more vulnerable. He may suffer from feelings of anxiety or guilt, and by consequence feel rejected by his family and segregated from his peers. In the case of over-protective parents, he may regress to infantile dependence or be in danger of learning passive, withdrawn, overly dependent behaviour.

A child who is temporarily or permanently handicapped will need much encouragement to learn, or to relearn, skills that are usually acquired spontaneously (e.g. grasping, walking, speaking, maintaining attention, enjoying human association). His condition affects the lives of his entire family — physically, socially, economically, and emotionally — and, in turn, is affected by the family's attitude toward him, his disability, and his future.

The psychological effects of long-term hospitalization should not be overlooked by parents, teacher, and others whose aim is to assist the pupil in his readjustment. He may have made strong friendships in the ward, whose loss may make him feel dejected when he returns home. He may have formed new insights into the consequences of his disability, and of abnormality in general, which may differ from the views of his parents. He may have suffered a loss of privacy and of dignity. Close contact with death, pain, and suffering, and observation of a variety of reactions to confinement and treatment may cause him to challenge family values and patterns.

Whatever the circumstances, the pupil will need opportunities to release some of his negative feelings and scope for self-expression in which to rebuild a self-image of a worthwhile, identifiable self. He may be capable of participating (i) at a pre-participation level (i.e., watching others), (ii) at a passive listening level (radio, television, films), (iii) at an assisted active level, or (iv) at an active level, but at all of these stages he will need a reasonable, consistent, and sustained system of guidance and discipline within which to formulate reliable guidelines and self-control.

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Appendix

Glossary

aniridia — the absence of the iris of the eye

aplasia — defective formation or development; lack of development

arthrodesis — surgical fixation of a joint

ataxia — failure of the muscular coordination; lack of balance

athetotis — affliction marked by continuous movements; involuntary motions

Bell's Palsy — facial paralysis

benign — not malignant

cerebral palsy — a persisting qualitative motor disorder due to a non-progressive damage to the brain

dorsiflexion — the act of bending a part backward

Erb's Palsy — paralysis due to degenerative changes in the spinal cord

Friedreich's Ataxia — hereditary ataxia, progressive

glandular fever — infectious mononucleosis

histoplasmosis — a disease characterized by irregular fever and emaciation; it is due to a yeast-like organism

Hodgkin's Disease — of the spleen and lymph nodes; pseudoleukemia

hydrocephaly — a condition in which there is excessive fluid in the head; the head is enlarged; usually associated with low intelligence

incontinence — lack of control of bladder or bowels or both

keloid — a new growth or tumor of the skin; tends to recur; sometimes tender and painful

Legg-Perthes—quiet hip disease in which upper end of femur becomes softened and remains so for approximately two years. Child's weight must not be borne during this time to avoid permanent disability of hip.

mononucleosis — glandular fever

myopia — near-sightedness

myositis — inflammation of a muscle

Oppenheim's Disease — congential myatonia or spasm of muscles

Osgood-Schlatter's Disease — inflammation of bone cartilage at upper portion of the tibia

Osler's Disease — chronic blueness with enlarged spleen and an excess of red corpuscles in the blood

osteo genesis imperfecta — imperfect development of the bone causing brittleness

perthes — see Legg-Perthes

phenylketonuria — congenital faulty metabolism often associated with retardation; PKU

pseudohypertrophy — increase of size with loss of function

pyemia — pus in the blood stream

retrolental fibroplasia — blindness caused by the use of too much oxygen during a premature infant's life in an incubator

spina bifoda — congenital cleft of the vertebral column with protrusion of the membraneous part of the cord

Still's Disease — inflammation of several joints together with enlarged spleen and lymph glands